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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      |  | (X2) MULTIPLE (<br>A. BUILDING | CONSTRUCTION   | COM                                 | E SURVEY<br>PLETED |
|---|----------------------|--|--------------------------------|--|-------------------------------------|--------------------|
|   |                      | 15E667   | B. WING                        |  | 02/24/2011                          |                    |
|   | PROVIDER OR SUPPLIER |  | 5225                           | TADDRESS, CITY, STATE, ZIP C<br>W MORRIS ST<br>NAPOLIS, IN46241                                  | ODE                                 |                    |
| (X4) ID                                       | SUMMARY S            | TATEMENT OF DEFICIENCIES                                 | ID                             | 1  |                                     | (X5)               |
| PREFIX<br>TAG                                 | (EACH DEFICIEN       | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG                  | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | RRECTION<br>HOULD BE<br>APPROPRIATE | COMPLETION DATE    |
|   |                      |  |                                | action was necessary.  |                                     |                    |
|   |                      |  |                                |  |                                     |                    |
|   |                      |  |                                |  |                                     |                    |
|   |                      |  |                                |  |                                     |                    |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  15E667 |                     | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |          |        | (X3) DATE (<br>COMPL<br><b>02/24/2</b>                               | ETED     |            |
|--|---------------------|---|----------|--------|--|----------|------------|
|  |                     | 102001                                  | B. WIN   |        |  | 02/2 1/2 |            |
| NAME OF P  | ROVIDER OR SUPPLIER |   |          |        | ADDRESS, CITY, STATE, ZIP CODE                                       |          |            |
| LYNHUR   | ST HEALTHCARE       |   |          |        | / MORRIS ST<br>IAPOLIS, IN46241                                      |          |            |
| (X4) ID  | SUMMARY S           | TATEMENT OF DEFICIENCIES                |          | ID     | PROVIDER'S PLAN OF CORRECTION  |          | (X5)       |
| PREFIX   | (EACH DEFICIEN      | CY MUST BE PERCEDED BY FULL             |          | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E        | COMPLETION |
| TAG  | REGULATORY OR       | LSC IDENTIFYING INFORMATION)            | <u> </u> | TAG    | DEFICIENCY)  |          | DATE       |
| F0253  | Based on observa    | ation, the facility failed to           | F02      | 53     | F02531)All residents have the  |          | 03/26/2011 |
| SS=C   | ensure the reside   | nt environment was                      |          |        | potential to be affected by this                                     |          |            |
|  | functional, by fai  | ling to ensure all window               |          |        | deficiency. The Administrator h had the Maintenance Director         | as       |            |
|  | · ·                 | l properly and drawers                  |          |        | replace window blinds , repair                                       | or       |            |
|  |                     | nal belongings functioned               |          |        | place orders for dresser   | <b>.</b> |            |
|  | • •                 | ding lights worked. The                 |          |        | drawers/dressers and   |          |            |
|  |                     |   |          |        | repair/replace reading lights. (                                     |          |            |
|  |                     | nctioning window blinds                 |          |        | Window blinds and reading  |          |            |
|  |                     | s who reside in rooms 7,                |          |        | lights, completed 2/28/2011.   |          |            |
|  |                     | The lack of proper                      |          |        | Orders for furniture to replace                                      |          |            |
|  | functioning wind    | ow blinds affected 10 out               |          |        | bedside tables in rooms 12,14 and 18, have been completed.           |          |            |
|  | of 36 residents w   | ho reside in the facility.              |          |        | The dresser drawer in room 7   |          |            |
|  | One set of vertical | al blinds in the                        |          |        | been repaired.)2) How the faci                                       |          |            |
|  | dining/activity ro  | oom did not function                    |          |        | will ID other resident having th                                     | -        |            |
|  |                     | lly affecting all 36                    |          |        | potential to be affected by the                                      |          |            |
|  |                     | ed the room. Drawers                    |          |        | same deficient practice and wh                                       |          |            |
|  |                     | ge of personal property                 |          |        | corrective action will be taken:                                     | An       |            |
|  | _                   |   |          |        | evaluation of each resident's room and of all common areas           |          |            |
|  |                     | s who reside in room 7,                 |          |        | has been completed. New  | •        |            |
|  |                     | ne non-functioning                      |          |        | dressers have been ordered a   | nd       |            |
|  |                     | 2 out of 36 residents who               |          |        | any malfunctioning personal  |          |            |
|  | reside in the facil | lity.                                   |          |        | furniture has been identified ar                                     | nd       |            |
|  |                     |   |          |        | repaired or has been ordered   |          |            |
|  | Findings include    | d:                                      |          |        | a furniture order) to be replace                                     | ed.(     |            |
|  |                     |   |          |        | Window blinds and reading  |          |            |
|  | During the 2/24/2   | 2011. 10:00 a.m                         |          |        | lights, completed 2/28/2011) Order was placed 3-9-11 for the         | ıree     |            |
|  | _                   | ur accompanied by the                   |          |        | (3) Heartland bedside 3 drawe  |          |            |
|  |                     | ance man, the following                 |          |        | cabinet.3) The systemic change                                       |          |            |
|  | _                   | _                                       |          |        | the facility has made, to preve                                      |          |            |
|  | concerns were ob    |   |          |        | reoccurrence of this tag:The   |          |            |
|  | · 1                 | ls did not function                     |          |        | Administrator and the  |          |            |
|  | 1 1 2               | s 7, 12, 14, and 18. The                |          |        | Maintenance Director made  | .i.      |            |
|  | blinds in room 7,   | 12, and 18 were missing                 |          |        | inspection/environmental roun  | as       |            |
|  | the adjustment ro   | ods.                                    |          |        | of the resident rooms and common areas on 2/28/2011.1                | -he      |            |
|  | In the main dinin   | g room/activity room,                   |          |        | Maintenance Director will mak  |          |            |
|  |                     | ord on one of the vertical              |          |        | his inspection rounds in each  | -        |            |
|  | <i>y</i>            |   |          |        |  |          |            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  COMPLETED |   |  |            |
|--|--|--|--|---|--|------------|
| ANDILAN  | OF CORRECTION  | 15E667   | A. BUILDING  |   | 02/24/2  |            |
|  |  | 10001  | B. WING  |   | 02/24/2  |            |
| NAME OF F  | ROVIDER OR SUPPLIER  |  |  | ADDRESS, CITY, STATE, ZIP CODE  |  |            |
| I YNHI ID  | ST HEALTHCARE  |  |  | V MORRIS ST<br>NAPOLIS, IN46241   |  |            |
|  |  |  |  | 1A1 OLIO, 11170271  |  |            |
| (X4) ID<br>PREFIX  |  | TATEMENT OF DEFICIENCIES  CV MUST BE REDGEDED BY FULL  | ID   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD  |  | (X5)       |
|  |  | CY MUST BE PERCEDED BY FULL  I SC IDENTIFYING INFORMATION)   | PREFIX   | CROSS-REFERENCED TO THE APPROL<br>DEFICIENCY)   | PRIATE   | COMPLETION |
| TAG  | blinds was stuck closed the blinds b) Two drawers belongings, in ro upward and appe One drawer in ro floor.  c) Reading light room 3 bed 2 and | and would not open or  used to store personal om 7, were tilting eared to be not on track. om 12 was sitting on the s would not turn on in | TAG  | resident room and all commareas, on a weekly basis for next three (3) months with written report given to the I of Nursing and the Administ After three (3) months, the inspection rounds will decrebi-weekly for two (2) month a written report given to the Director of Nursing and the Administrator. After the latter (2) month period the inspection rounds will decrease to an basis, with written reports of the Director of Nursing, the Administrator and the Housekeeping Supervisor. Will be 'No Stop Date' place the monthly inspection rounds. The Administrator (designee) will also make the monthly inspection rounds, accompanied by the Direct Nursing. All inspection rounds and the corrective actions for F0253: The Maintenance D will be responsible to docur all inspection rounds, to incomman and the Administrator of the facility. The Maintenance D will make his inspection rounds and the Administrator of the facility. The Maintenance D will make his inspection rounds and the Administrator of the facility. The Maintenance D will make his inspection rounds and the Administrator of the facility. The Maintenance D will make his inspection rounds and the Administrator of the facility. The Maintenance D will make his inspection rounds and the Administrator of the facility. The Maintenance D will make his inspection rounds and the Administrator of the facility. The Maintenance D will make his inspection rounds and the Administrator of the facility. The Maintenance D will make his inspection rounds and the Administrator of the facility. The Maintenance D will make his inspection rounds. | non or the a Director trator. ease to es; with er two ction nonthly given to  There ed on or her ese or of ds will form.4) ttoring or irector ment clude esing er irector ment clude irector unds in y | DATE       |
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PRINTED: 04/08/2011 FORM APPROVED OMB NO. 0938-0391

| NAME OF PROVIDER OR SUPPLIER  (N.9) ID  SIMMARY STATIMENT OF DIRECTION.  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  REGULATORY OR LSC IDLINITRYING INFORMATION)  Administrator and the Housekeeping Supervisor. After the (3) months, the inspection rounds will decrease to bi-weekly for two (2) month period the inspection rounds will decrease to a monthly basis, with written report given to the Director of Nursing, ithe Administrator and the Housekeeping Supervisor. There will be 'No Stop Date' placed on the monthly) inspection/environmental rounds. The Administrator for her designee) will also make these monthly inspection rounds, accompanied by the Director of Nursing, and inspection rounds, will be documented in written form.  |        |                | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO<br>A. BUILDING | DNSTRUCTION  | (X3) DATE SURVEY COMPLETED 02/24/2011                       |            |
|---|--------|----------------|---|---------------------------------|--|---|------------|
| NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE  (X4) ID  PREFIX  TAG  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  Administrator and the  Housekeeping Supervisor. After  three (3) months, the inspection  rounds will decrease to bi-weekly  for two (2) months; with a written  report given to the Director of  Nursing and the  Administrator and the  Housekeeping Supervisor. After three (3) month period the inspection  rounds will decrease to a monthly  basis, with written reports given to  the Director of Nursing ,the  Administrator and the  Housekeeping Supervisor. There  will be 'No Stop Date' placed on  the monthly  inspection/environmental  rounds. The Administrator (or her  designee) will also make these  monthly inspection rounds,  accompanied by the Director of  Nursing, All  inspection/environmental rounds  will be documented in written |        |                | 15E667  |                                 |  | 02/24/20  |            |
| PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Administrator and the Housekeeping Supervisor. After three (3) months, the inspection rounds will decrease to bi-weekly for two (2) months; with a written report given to the Director of Nursing and the Administrator.After the latter two (2) month period the inspection rounds will decrease to a monthly basis, with written reports given to the Director of Nursing, the Administrator and the Housekeeping Supervisor. There will be 'No Stop Date' placed on the monthly inspection/environmental rounds. The Administrator (or her designee) will also make these monthly inspection rounds, accompanied by the Director of Nursing, All inspection/environmental rounds will be documented in written  |        |                |   | 5225 W                          | / MORRIS ST  |   |            |
| Housekeeping Supervisor. After three (3) months, the inspection rounds will decrease to bi-weekly for two (2) months; with a written report given to the Director of Nursing and the Administrator. After the latter two (2) month period the inspection rounds will decrease to a monthly basis, with written reports given to the Director of Nursing ,the Administrator and the Housekeeping Supervisor. There will be 'No Stop Date' placed on the monthly inspection/environmental rounds. The Administrator (or her designee) will also make these monthly inspection rounds, accompanied by the Director of Nursing.All inspection/environmental rounds will be documented in written  | PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL                       | PREFIX                          | (EACH CORRECTIVE ACTION SHOULD BI  | 3   | COMPLETION |
|   | IAU    | ALGOLATORI OK  | ESC IDENTIFIED INFORMATION)                       | IAU                             | Administrator and the Housekeeping Supervisor. At three (3) months, the inspect rounds will decrease to bi-we for two (2) months; with a wr report given to the Director of Nursing and the Administrator. After the latter (2) month period the inspect rounds will decrease to a mobasis, with written reports given the Director of Nursing, the Administrator and the Housekeeping Supervisor. Twill be 'No Stop Date' placed the monthly inspection/environmental rounds. The Administrator (of designee) will also make the monthly inspection rounds, accompanied by the Director Nursing. All inspection/environmental rounds. The documented in writter will be documented in writter | ofter ction eekly itten of two ion onthly een to There I on | DAIL       |

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|               | T OF DEFICIENCIES<br>OF CORRECTION   | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |               |   | (X3) DATE SURVEY  COMPLETED  02/24/2011                 |     |
|---------------|--|---|---|---------------|---|---|-----|
|               |  | 132007  | B. WING                                 |               |   | 02/24/2011  |     |
|               | PROVIDER OR SUPPLIER   |   |   | 5225 W        | ADDRESS, CITY, STATE, ZIP CODE  / MORRIS ST  JAPOLIS, IN46241   |   |     |
| (X4) ID       | SUMMARY S  | TATEMENT OF DEFICIENCIES  |   | ID            | 1   | (X5)  |     |
| PREFIX<br>TAG | (EACH DEFICIEN   | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  |   | PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  | COMPLET   | ION |
| F0282         | A. Based on reco   | ord review and interview,   | F02                                     | 82            | F02821) What actions will be  | 03/26/2   | 011 |
| F0282<br>SS=E | the facility failed orders for laborat followed in a tim residents reviewed services in a same ensure the plan or resident receiving 10. (Residents # B. Based on receive the facility failed his blood pressur administration of by the physician. residents reviewed physician's order administration of (Resident #36)  Findings included A. A current factor provided by the Son 2/21/2011, un Medical Care and resident have the necessary to attain highest practicab. | to ensure physician tory services were ely manner for 3 of 10 ed for timely laboratory ple of 10 and failed to f care was followed for a g dialysis for 1 of 1 g dialysis in a sample of 32, 5, 9, 36)  ord review and interview, to ensure a resident had taken prior to their medication, as ordered  This affected 1 of 10 ed for following is related to medication at of a sample of 10. | F02                                     | 82            | F02821) What actions will be accomplished for those reside found to have been affected by the deficeint practice:A) (requirement)All residents hav the potential to be affected by deficeincy. However, under furth noted to be affected negatively this particular instance. The fact realizes it's part in the safe keeping, safe medication administration and the practice safely monitoring medications. The facility takes realization seriously. 3-16-2017. The facility interviewed a new laboratory agency; Med Lab at found them to have improved upon laboratory measures that are utilized in Geriatric Facilities. The facility has accepted their offer to service our residents. There, according to contractur agreements, could be a 60 day waiting period to make the change form one laboratory to other. On 3-16-2011 the ARNP was made aware of lab difficult and audited residents for any ladjustments. The Director of Nursing (or her designee) will audit labs and lab orders each month for the remainder of 2011. Dialysis for resident #36: Circle Center Dialysis/Lis was contacted 3-16-11, by this author. This dialysis center, as dialysis centers do, perform certain vital sign measurement and weights, along with other | ethis her was in ility  of this had  s. al  the ties ab | 011 |
|               |  | _   |   |               |   |   |     |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) |                      | (X2) MU                      | (X2) MULTIPLE CONSTRUCTION |             | (X3) DATE SURVEY   |         |            |
|---|----------------------|------------------------------|----------------------------|-------------|--|---------|------------|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER:       | л ріш                      | A. BUILDING |  | COMPL   | ETED       |
|   |                      | 15E667                       | B. WING                    |             |  | 02/24/2 | 011        |
|   |                      | 1                            | D. WITE                    |             | ADDRESS, CITY, STATE, ZIP CODE                                     |         |            |
| NAME OF I   | PROVIDER OR SUPPLIEF | ₹                            |                            |             | / MORRIS ST  |         |            |
| LYNHUR  | RST HEALTHCARE       |                              |                            |             | APOLIS, IN46241  |         |            |
|   |                      |                              |                            |             |  |         |            |
| (X4) ID   |                      | STATEMENT OF DEFICIENCIES    |                            | ID          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |         | (X5)       |
| PREFIX  |                      | NCY MUST BE PERCEDED BY FULL |                            | PREFIX      | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                   | ATE     | COMPLETION |
| TAG   | <b>+</b>             | LSC IDENTIFYING INFORMATION) |                            | TAG         |  |         | DATE       |
|   | 1 1 1                | 04/2000 and revised on       |                            |             | testing that is normally sent to each facility. This was not fou   |         |            |
|   | · ·                  | ed "Staffwill be             |                            |             | to be the case with Lynhurst                                       | iiu     |            |
|   | monitoredby tl       | heir perspective             |                            |             | Healthcare and the dialysis co                                     | enter   |            |
|   | supervisors to er    | sure that the residents      |                            |             | was advised and agreed to se                                       |         |            |
|   | receive appropri     | ate care and services"       |                            |             | paperwork via fax monthly.   |         |            |
|   |                      |                              |                            |             | (summaries of care). The cen                                       |         |            |
|   | 1. The clinical re   | ecord review for Resident    |                            |             | also was advised and agrees  | with    |            |
|   |                      | ed on 2/22/2011 at 1:50      |                            |             | the following:The facility has composed a "Dialysis Fol            | rm"     |            |
|   |                      | 3d 011 2/22/2011 dt 1.50     |                            |             | which will accompany the res                                       |         |            |
|   | p.m.                 |                              |                            |             | to the dialysis center,each  | ident   |            |
|   |                      | D :1 . //22 : 1 1 1          |                            |             | scheduled visit; where the nu                                      | rses    |            |
|   | 1                    | or Resident #32 included,    |                            |             | at dialysis will complete the fo                                   | rm      |            |
|   |                      | ited to, schizophrenia,      |                            |             | and send it back to this facility                                  |         |            |
|   | bipolar affective    | disorder, anxiety,           |                            |             | when the resident returns from                                     | n       |            |
|   | transient cerebra    | l ischemia, and              |                            |             | dialysis. This form lists blood                                    |         |            |
|   | osteoporosis.        |                              |                            |             | pressures before and after the dialysis treatment, along with      | 9       |            |
|   |                      |                              |                            |             | weights and any labs or  |         |            |
|   | A physician's ord    | der dated 7/26/2010,         |                            |             | contraindications that may ha                                      | ve      |            |
|   | 1                    | ent #32 was to have a        |                            |             | occurred with the dialysis   |         |            |
|   |                      | count (CBC), a complete      |                            |             | treatment.These forms will   |         |            |
|   | _                    | (CMP), and liver function    |                            |             | become a part of the resident                                      |         |            |
|   | 1                    | * **                         |                            |             | medical records.Resident #9:                                       |         |            |
|   | · ·                  | months. A physician's        |                            |             | This resident was previously planned for non-compliance v          |         |            |
|   |                      | /2010, indicated Resident    |                            |             | care, including laboratory   | VILII   |            |
|   | #32 was to have      | a single vitamin D level     |                            |             | testings. Therefore, should the                                    | е       |            |
|   | drawn. A physic      | cian's order dated           |                            |             | resident refuse, the facility wil                                  |         |            |
|   | 10/28/2010, indi     | cated Resident #32 was       |                            |             | again and again but it is felt to                                  | be      |            |
|   | to have a single     | vitamin D level drawn.       |                            |             | within this resident's rights to                                   |         |            |
|   |                      |                              |                            |             | refuse. Risks and benefits are                                     | 9       |            |
|   | Review of the la     | b reports for Resident #32   |                            |             | explained and the attending doctor is kept aware. The faci         | lity    |            |
|   |                      | CMPs, and liver function     |                            |             | has also had Psych services  | y       |            |
|   |                      | leted on 7/27/2010 and       |                            |             | attempt to evaluate this reside                                    | ent,    |            |
|   | _                    | e were no lab results        |                            |             | several times, to which she al                                     |         |            |
|   |                      |                              |                            |             | refuses and also has that righ                                     |         |            |
|   |                      | art for the October          |                            |             | do so.B) (requirement)The fac                                      | -       |            |
|   | CBC,CMP, and         | liver function tests that    |                            |             | started a new form on 3-4-11                                       | tO      |            |
|   |                      |                              |                            |             |  |         |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                              |                              | (X2) MULTIPLE CONSTRUCTION |             |   | (X3) DATE S<br>COMPL |            |
|--|------------------------------|------------------------------|----------------------------|-------------|---|----------------------|------------|
| AND PLAN   | OF CORRECTION                | IDENTIFICATION NUMBER:       | A. BUI                     | A. BUILDING |   |                      |            |
|  |                              | 15E667                       | B. WIN                     | G           |   | 02/24/2              | U11        |
| NAME OF 1  | PROVIDER OR SUPPLIER         | 3                            | -                          | STREET A    | ADDRESS, CITY, STATE, ZIP CODE                                      |                      |            |
| TAXINE OF I  | , IDER OR SUIT EIEF          | •                            |                            | 1           | / MORRIS ST   |                      |            |
| LYNHUR   | ST HEALTHCARE                |                              |                            | INDIAN      | IAPOLIS, IN46241  |                      |            |
| (X4) ID  | SUMMARY S                    | STATEMENT OF DEFICIENCIES    |                            | ID          | PROVIDER'S PLAN OF CORRECTION                                       |                      | (X5)       |
| PREFIX   | ` `                          | ICY MUST BE PERCEDED BY FULL |                            | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | re l                 | COMPLETION |
| TAG  | REGULATORY OR                | LSC IDENTIFYING INFORMATION) | $\bot$                     | TAG         | DEFICIENCY)   |                      | DATE       |
|  | were ordered eve             | ery three months on          |                            |             | ensure proper documentation   | of                   |            |
|  | 7/26/2010. The               | re were no lab results for   |                            |             | all necessary vital sign measurements for all                       |                      |            |
|  | the 8/12/2010 vi             | tamin D level and there      |                            |             | residents.Staff who are found                                       | to                   |            |
|  | were two results             | for the vitamin D level      |                            |             | be non compliant with any   |                      |            |
|  | ordered on 10/28             | 3/2010. One of the           |                            |             | doctors orders, including the                                       |                      |            |
|  |                              | s was dated 11/3/2010        |                            |             | documentaion of required vital                                      |                      |            |
|  |                              | s dated 11/8/2010. There     |                            |             | signs, will be given written  |                      |            |
|  |                              |                              |                            |             | counsel and placed into the   |                      |            |
|  |                              | ated 1/26/2011, and a        |                            |             | facility's corrective step  |                      |            |
|  | 1 *                          | ulture and sensitivity       |                            |             | program.3-16-11 This author contacted the facilitys pharma          | cv                   |            |
|  | · ·                          | in which there was no        |                            |             | and is requesting follow up   | ~ <i>y</i>           |            |
|  | 1                            | n's order provided for       |                            |             | medication administration   |                      |            |
|  | these test.                  |                              |                            |             | in-services for those nurses ar                                     | nd                   |            |
|  |                              |                              |                            |             | Qualified Medication Aides that                                     | ıt                   |            |
|  | In an interview v            | with the Director of         |                            |             | sign off on medication sheets.                                      |                      |            |
|  | Nursing (DON)                | and the Administrator on     |                            |             | The facility is also requesting                                     |                      |            |
|  | 1                            | 5 p.m., in regard to the     |                            |             | supervised medication pass w<br>a pharmacy representative, fo       |                      |            |
|  |                              | oratory tests being done     |                            |             | facility Qualified Medication                                       | ı alı                |            |
|  |                              |                              |                            |             | Aides.In-services for nurses a                                      | nd                   |            |
|  |                              | performed not having a       |                            |             | QMA's will be done four times                                       |                      |            |
|  |                              | r, they indicated they were  |                            |             | year regarding the medication                                       |                      |            |
|  | _                            | roblem existed with the      |                            |             | pass and the documentations   |                      |            |
|  |                              | ce and that they were in     |                            |             | required thereof.2) How the   |                      |            |
|  | the process of ac            | equiring another             |                            |             | facility will identify other reside                                 |                      |            |
|  | laboratory to pro            | ovide their service. The     |                            |             | having the potential to be affect<br>by the same deficient practice | Ji <del>c</del> u    |            |
|  | DON indicated t              | he nurses are responsible    |                            |             | and what corrective actions wi                                      |                      |            |
|  | for ordering the             | •                            |                            |             | be taken:All residents have the                                     |                      |            |
|  |                              |                              |                            |             | potential to be affected by this                                    |                      |            |
|  | 2 The clinical re            | ecord for Resident #5 was    |                            |             | deficeincy.However, under fur                                       |                      |            |
|  | reviewed on 2/23             |                              |                            |             | physician review, no resident                                       |                      |            |
|  | Teviewed on 2/23             | o/ 11 at 2.25 p.m.           |                            |             | noted to be affected negatively                                     | / in                 |            |
|  | 771 1: 0                     | D :1 //// 1 1 1              |                            |             | this particular instance. It was noted by our surveyors that th     | ا                    |            |
|  | _                            | or Resident #5 included,     |                            |             | facility's present contracted                                       | <b>`</b>             |            |
|  |                              | ited to, insulin dependent   |                            |             | laboratory services, were not                                       |                      |            |
|  |                              | s, hypertension, chronic     |                            |             | complying with doctor ordered                                       |                      |            |
|  | kidney disease, o            | congestive heart failure,    |                            |             | time schedules in some  |                      |            |
|  |                              |                              |                            |             |   |                      |            |
| FORM CMS-2   | 2567(02-99) Previous Version | ons Obsolete Event ID: (     | C1I711                     | Facility    | ID: 000385 If continuation s  | neet Pa              | ge 8 of 30 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X |                      |                              | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |             |   | SURVEY  |            |
|---|----------------------|------------------------------|---|-------------|---|---------|------------|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER:       | A BIIII                                     | A. BUILDING |   |         | ETED       |
|   |                      | 15E667                       | B. WIN                                      |             |   | 02/24/2 | 011        |
|   |                      |                              | D. WIIV                                     |             | ADDRESS, CITY, STATE, ZIP CODE                                      |         |            |
| NAME OF   | PROVIDER OR SUPPLIER | R                            |   | 1           | / MORRIS ST   |         |            |
| LYNHURST HEALTHCARE                                     |                      |                              |   | 1           | IAPOLIS, IN46241  |         |            |
|   |                      |                              |   |             |   |         |            |
| (X4) ID   |                      | STATEMENT OF DEFICIENCIES    |   | ID          | PROVIDER'S PLAN OF CORRECTION                                       |         | (X5)       |
| PREFIX  |                      | ICY MUST BE PERCEDED BY FULL |   | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE      | COMPLETION |
| TAG   | ŧ                    | LSC IDENTIFYING INFORMATION) | -   | TAG         | DEFICIENCY)   |         | DATE       |
|   | and vascular den     | nentia with delirium.        |   |             | instances. Residents 32-36-5  |         |            |
|   |                      |                              |   |             | (three- out of a possible 40  | :41-    |            |
|   | A physician's ord    | der dated 5/14/2010,         |   |             | residents.)The facility realizes part in the safe keeping, safe     | II S    |            |
|   |                      | nt #5 was to have a          |   |             | medication administration ,the                                      |         |            |
|   |                      | C every 3 months.            |   |             | practice of safely monitoring                                       |         |            |
|   | l licinoglobiii 7110 | every 5 months.              |   |             | medications and laboratory  |         |            |
|   | D : 0.1 1 :          | 1                            |   |             | orders.The facility takes this                                      |         |            |
|   |                      | b reports for Resident #5    |   |             | realization seriously.3-16-201                                      |         |            |
|   | _                    | lobin A1C tests were         |   |             | The facility interviewed a new                                      |         |            |
|   | completed for M      | ay and August. The           |   |             | laboratory agency; Med Lab a  | nd      |            |
|   | November 2011        | hemoglobin A1C was           |   |             | found them to have improved   |         |            |
|   | done on 10/29/20     | 010 and the February         |   |             | upon laboratory measures tha  |         |            |
| 2011 hemoglobin A1C was done on                         |                      |                              |   |             | are utilized in Geriatric Facilitie The facility has accepted their |         |            |
|   | _                    | re was a urinalysis done     |   |             | offer to service our residents.                                     |         |            |
|   |                      |                              |   |             | 3-16-2011 the ARNP was made   |         |            |
|   |                      | which there was no           |   |             | aware of lab difficulties and                                       |         |            |
|   | physician's order    | r.                           |   |             | audited residents for any orde                                      | red     |            |
|   |                      |                              |   |             | lab adjustments. Lab work has                                       |         |            |
|   | In an interview v    | with the Director of         |   |             | been completed.The Director   | of      |            |
|   | Nursing (DON)        | and the Administrator on     |   |             | Nursing (or her designee) will                                      |         |            |
|   |                      | 5 p.m., in regard to the     |   |             | audit labs and lab orders each                                      | 1       |            |
|   |                      | oratory tests being done     |   |             | month for the remainder of  |         |            |
|   |                      | _                            |   |             | 2011.As of April 1st 2011, the actual "MAR" (medication             |         |            |
|   |                      | performed not having a       |   |             | administration records, will be                                     |         |            |
|   |                      | , they indicated that they   |   |             | delivered pre-printed with wha                                      |         |            |
|   | were unaware th      | at a problem existed with    |   |             | particular vital signs must be                                      |         |            |
|   | the laboratory se    | rvice, and they were in      |   |             | taken prior to and/or after   |         |            |
|   | the process of ac    | quiring another              |   |             | particular medication   |         |            |
|   | laboratory to pro    | ovide their service. The     |   |             | admininstration. ( Re-writes do                                     |         |            |
|   | 1                    | he nurses are responsible    |   |             | not begin until the beginning o                                     | of      |            |
|   | for ordering the     | •                            |   |             | the month.)As of March 26th   |         |            |
|   | lor ordering the     | iuoo.                        |   |             | 2011, the acting Unit Manager be responsible to check the           | WIII    |            |
|   | 2 771 1: : 1         | 1.C. D. 11                   |   |             | Medication Administration   |         |            |
|   |                      | ecord for Resident #9 was    |   |             | Records on a daily basis for a                                      | 14      |            |
|   | reviewed on 2/23     | 3/2011 at 10:07 a.m.         |   |             | day period (documented); the  |         |            |
|   |                      |                              |   |             | weekly basis for a 4 month pe                                       |         |            |
|   | The diagnoses for    | or Resident #9 included,     |   |             | (documented); followed by a   |         |            |
|   |                      | •                            |   |             | İ   |         |            |
|   | !                    |                              |   |             | !   |         |            |

000385

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |  |                              | (X2) MULTIPLE CONSTRUCTION |                    |  | (X3) DATE S | SURVEY     |
|---|--|------------------------------|----------------------------|--------------------|--|-------------|------------|
| AND PLAN  | OF CORRECTION                            | IDENTIFICATION NUMBER:       | A. BUILDING                |                    |  | COMPLETED   |            |
|   |  | 15E667                       | 1                          | B. WING 02/24/2011 |  | 011         |            |
|   |  |                              | B. WIN                     |                    | ADDRESS, CITY, STATE, ZIP CODE   |             |            |
| NAME OF I   | PROVIDER OR SUPPLIEF                     | ₹                            |                            |                    |  |             |            |
| 13/411115   | OT 115 ALTUO A DE                        |                              |                            | 1                  | / MORRIS ST  |             |            |
| LYNHUR  | RST HEALTHCARE                           |                              |                            | INDIAN             | IAPOLIS, IN46241   |             |            |
| (X4) ID   | SUMMARY S                                | STATEMENT OF DEFICIENCIES    |                            | ID                 | PROVIDER'S PLAN OF CORRECTION  |             | (X5)       |
| PREFIX  | (EACH DEFICIEN                           | ICY MUST BE PERCEDED BY FULL |                            | PREFIX             | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE          | COMPLETION |
| TAG   | REGULATORY OR                            | LSC IDENTIFYING INFORMATION) |                            | TAG                | DEFICIENCY)  | . =         | DATE       |
|   | but were not lim                         | ited to, insulin dependent   |                            |                    | monthly basis (documented) for   | or          |            |
|   |  | s, cardiomegaly, chronic     |                            |                    | the remainder of the year2011  |             |            |
|   |  | - ·                          |                            |                    | Also the acting Unit Manager   |             |            |
|   | 1  | nonary disease, seizures,    |                            |                    | be providing follow up with the  |             |            |
|   | and osteoporosis                         | <b>5.</b>                    |                            |                    | nurses or QMA's accountable,   |             |            |
|   |  |                              |                            |                    | should there be "holes" (  |             |            |
|   | A physician's ord                        | der dated 7/7/2010,          |                            |                    | undocumented segments), for  |             |            |
|   |  | nt #9 was to have a          |                            |                    | those "holes" and to ensure th   |             |            |
|   |  | C, complete metabolic        |                            |                    | the vital signs are being record                                       | ded         |            |
|   | _  | -                            |                            |                    | properly.Resident #9: This   |             |            |
|   | 1 * '                                    | lantin level every 3         |                            |                    | resident was previously care planned for non-compliance w              | ith         |            |
|   | months.                                  |                              |                            |                    | care, including laboratory   | TUT         |            |
|   |  |                              |                            |                    | testings. Therefore, should the  | ۵.          |            |
|   | Review of the la                         | b reports for Resident #9    |                            |                    | resident refuse, the facility will                                     |             |            |
|   |  | results for January 2011.    |                            |                    | again and again but it is felt to                                      |             |            |
|   |  |                              |                            |                    | within this resident's rights to                                       |             |            |
|   | There were resul                         |                              |                            |                    | refuse. Risks and benefits are   |             |            |
|   |  | re were reports from the     |                            |                    | explained and the attending  |             |            |
|   | laboratory indica                        | ating the tests were         |                            |                    | doctor is kept aware. The facil  | ity         |            |
|   | canceled on Janu                         | ary 3, 4, 12, 14, and 18.    |                            |                    | has also had Psych services  |             |            |
|   | There were phys                          | ician progress notes dated   |                            |                    | attempt to evaluate this reside  |             |            |
|   |  | ating on 1/3/2011 and        |                            |                    | several times, to which she als  |             |            |
|   | · ·                                      | e tests were canceled due    |                            |                    | refuses and also has that right  |             |            |
|   |  |                              |                            |                    | do so.3) What systemic chang   | jes         |            |
|   | _  | ed or the release was not    |                            |                    | will be made to ensure the deficient practice does not                 |             |            |
|   | signed.                                  |                              |                            |                    | recur:Laboratory Issues:All  |             |            |
|   |  |                              |                            |                    | residents have the potential to  | he          |            |
|   | In an interview v                        | with the Director of         |                            |                    | affected by this   |             |            |
|   | Nursing (DON)                            | and the Administrator on     |                            |                    | deficeincy.However, under fur  | ther        |            |
|   | 1  | 5 p.m., in regard to the     |                            |                    | physician review, no resident  |             |            |
|   |  | 1 , 0                        |                            |                    | noted to be affected negatively  |             |            |
|   |  | oratory tests being done     |                            |                    | this particular instance.3-16-2  |             |            |
|   |  | erformed not having a        |                            |                    | The facility interviewed a new   |             |            |
|   | physician's order                        | r, they indicated they were  |                            |                    | laboratory agency; Med Lab a   | nd          |            |
|   | unaware that a p                         | roblem existed with the      |                            |                    | found them to have improved  | ,           |            |
|   | laboratory service, and they were in the |                              |                            |                    | upon laboratory measures tha   |             |            |
|   |  | ring another laboratory      |                            |                    | are utilized in Geriatric Facilitie                                    |             |            |
|   | 1 -                                      | vice. The DON indicated      |                            |                    | The facility has accepted their offer to service our residents.        |             |            |
|   | provide tileli ser                       | vice. The DON indicated      |                            |                    | oner to service our residerits.t                                       | -au         |            |
|   |  |                              |                            |                    |  |             |            |

000385

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X |                      |                              | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |             |  | SURVEY  |            |  |
|---|----------------------|------------------------------|---|-------------|--|---------|------------|--|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER:       | A BIIII                                     | A. BUILDING |  |         | COMPLETED  |  |
|   |                      | 15E667                       | B. WIN                                      |             |  | 02/24/2 | 011        |  |
|   |                      |                              | B. WIN                                      |             | ADDRESS, CITY, STATE, ZIP CODE   |         |            |  |
| NAME OF I   | PROVIDER OR SUPPLIEF | 2                            |   |             | MORRIS ST  |         |            |  |
| LYNHUR  | ST HEALTHCARE        |                              |   | 1           | APOLIS, IN46241  |         |            |  |
|   |                      |                              |   |             | 71 OLIO, 111102 11   |         |            |  |
| (X4) ID   |                      | STATEMENT OF DEFICIENCIES    |   | ID          | PROVIDER'S PLAN OF CORRECTION  |         | (X5)       |  |
| PREFIX  | · ·                  | CY MUST BE PERCEDED BY FULL  |   | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) | ΓE      | COMPLETION |  |
| TAG   |                      | LSC IDENTIFYING INFORMATION) | +   | TAG         | · · · · · · · · · · · · · · · · · · ·  |         | DATE       |  |
|   |                      | sponsible for ordering the   |   |             | results and refusals are then followed by this new lab and                             |         |            |  |
|   | labs.                |                              |   |             | made available to the facility v   | ia      |            |  |
|   |                      |                              |   |             | fax and on line. This lab also ha  |         |            |  |
|   | 4. The clinical re   | ecord for Resident #36       |   |             | a customer service representa  |         |            |  |
|   | was reviewed on      | 2/22/2011 at 11:15 a.m.      |   |             | who will be scenduled to come  | ,       |            |  |
|   |                      |                              |   |             | into the facility and audit order  |         |            |  |
|   | The diagnoses for    | or Resident #36 included,    |   |             | labs, completed labs, etc. Vital   |         |            |  |
|   | 1                    | ited to, end stage renal     |   |             | Signs Issue:As of March 26th 2011, the acting Unit Manager                             | will    |            |  |
|   |                      | lependent diabetes           |   |             | be responsible to check the  | *****   |            |  |
|   | · ·                  | e gastroparesis, and         |   |             | Medication Administration  |         |            |  |
|   |                      | gastroparesis, and           |   |             | Records on a daily basis for a   | 14      |            |  |
|   | hypertension.        |                              |   |             | day period (documented); ther  |         |            |  |
|   |                      |                              |   |             | weekly basis for a 4 month per   | riod    |            |  |
|   |                      | rd had no reports given to   |   |             | (documented); followed by a  |         |            |  |
|   |                      | the dialysis center with     |   |             | monthly basis (documented) for the remainder of the year 2011                          |         |            |  |
|   | the details from     | the dialysis session. A      |   |             | Also the acting Unit Manager   |         |            |  |
|   | nursing note date    | ed 12/2/2011 indicated       |   |             | be providing follow up with the  |         |            |  |
|   | the facility, "rece  | eived a good report from     |   |             | nurses or QMA's accountable,   |         |            |  |
|   | 1                    | iders," but did not          |   |             | should there be "holes" (  |         |            |  |
|   | 1                    | tal signs or lab results     |   |             | undocumented segments), for  |         |            |  |
|   | •                    | during the dialysis          |   |             | those "holes" and to ensure th   |         |            |  |
|   |                      | rsing noted dated            |   |             | the vital signs are being record properly. As of April 1st 2011, t                     |         |            |  |
|   |                      | _                            |   |             | actual "MAR" (medication   | i i e   |            |  |
|   | · ·                  | ted the dietitian from the   |   |             | administration records, will be  |         |            |  |
|   | 1 -                  | alled about the resident's   |   |             | delivered pre-printed with wha   | t       |            |  |
|   | _                    | ated physician's order       |   |             | particular vital signs must be   |         |            |  |
|   | indicated to, "che   | eck shunt site every shift   |   |             | taken prior to and/or after  |         |            |  |
|   | for positive thrill  | and bruit and document       |   |             | particular medication  |         |            |  |
|   | on the treatment     | sheet."                      |   |             | admininstration. ( Re-writes do not begin until the beginning o                        |         |            |  |
|   |                      |                              |   |             | the month.)Dialysis for resider  |         |            |  |
|   | During an interv     | iew with the                 |   |             | #36: (and future dialysis  |         |            |  |
|   |                      | n 2/23/2011 at 2:20 p.m.,    |   |             | residents)Circle Center  |         |            |  |
|   |                      | ng a policy for the          |   |             | Dialysis/Lisa, was contacted   |         |            |  |
|   |                      | re for dialysis residents    |   |             | 3-16-11, by this author. This  |         |            |  |
|   |                      | •                            |   |             | dialysis center, as all dialysis   | _       |            |  |
|   | coming from dia      | lysis back to the facility,  |   |             | centers do, perform certain vita   | aı      |            |  |
|   |                      |                              |   |             |  |         |            |  |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  | CONSTRUCTION           | (X3) DATE SURVEY  COMPLETED  |  |
|--|--|--|------------------------|--|--|
| 111,212,111  | or condition   | 15E667   | A. BUILDING<br>B. WING |  | 02/24/2011   |
|  |  |  |                        | TT ADDRESS, CITY, STATE, ZIP CODE                                      |  |
| NAME OF F  | PROVIDER OR SUPPLIER   |  | 5225                   | W MORRIS ST  |  |
| LYNHUR   | ST HEALTHCARE  |  | INDIA                  | ANAPOLIS, IN46241  | _  |
| (X4) ID  |  | TATEMENT OF DEFICIENCIES   | ID                     | PROVIDER'S PLAN OF CORRECTION  | (X5)   |
|  | `  |  | 1                      | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                          | TE   |
| PREFIX<br>TAG  | she indicated the current policy.  B.1. The record reviewed on 2/22 Diagnoses for Rewere not limited disease, insulin disease | for Resident #36 was 2/2011 at 11:15 a.m. esident #36 included, but to, end stage renal dependent diabetes ansion, and anemia.  Let that originated upon 26/2010 indicated the ave his blood pressure administration of the resident took at 9 except for the days he on Tuesdays, Thursdays, which he did not take administration records for icated he did not have his ken for the following prior to the administration l.  1, 24, 26, and 29.  7, 11, 14, 17, 18, 24, 25, | PREFIX TAG             | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | completion DATE  this, string with and string with a |
|  | - r, -, -, -, -,   | 9, 10, 12, 13, and 19.   |                        | results and refusals are then  |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15E667 |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                       | (X3) DATE SURVEY  COMPLETED  02/24/2011  |   |  |  |
|---|---|---|-----------------------|--|---|--|--|
|   |   | 15E00 <i>1</i>  | B. WING               | EET ADDRESS, CITY, STATE, ZIP CODE   |   |  |  |
| NAME OF F   | PROVIDER OR SUPPLIER  |   | 5225 W MORRIS ST      |  |   |  |  |
| LYNHUR  | ST HEALTHCARE   |   | INDIANAPOLIS, IN46241 |  |   |  |  |
| (X4) ID<br>PREFIX   | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL  | ID<br>PREFIX          | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT   |   |  |  |
| TAG   | January 2011: 9 a.m.: 3, 9, 10, 5 p.m.: 1, 3, 5, 1 February 2011: 9 a.m.: 4 and 14  During exit on 2/ more documenta regard to blood p prior to the admir medication, Meto report sheets and were produced ex | 223/2011 at 5:45 p.m., tion was requested in pressures being assessed inistration of the opprolol. Several 24 hour CNAs vital sign sheets except for the above dates of could not provide | TAG                   | followed by this new lab and made available to the facility of fax and on line. This lab also had customer service representate who will be scehduled to come into the facility and audit order labs, completed labs, etc.3-16-2011 The facility interviewed a new laboratory agency; Med Lab and found the to have improved upon laboral measures that are utilized in Geriatric Facilities. The facility has accepted their offer to service our residents. On 3-16-2011 the ARNP was made aware of lab difficulties and audited resident for any ordered lab adjustments. Lab work has be completed. The Director of Nursing (or her designee) will audit labs and lab orders each month for the remainder of 2011. Vital Signs Issue: As of March 26th 2011, the acting U Manager will be responsible to check the Medication Administration Records on a decent basis for a 14 day period (documented); then a weekly basis for a 4 month period (documented); followed by a monthly basis (documented) followe | as titive e e e e e e e e e e e e e e e e e e |  |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15E667 |  | (X2) MULTIPLE CO  | )NSTRUCTION        | (X3) DATE SURVEY  COMPLETED  02/24/2011                                      |  |                      |
|---|--|---|--------------------|--|--|----------------------|
|   | ROVIDER OR SUPPLIER                    |   | 5225 W             | ADDRESS, CITY, STATE, ZIP CODE<br>V MORRIS ST<br>VAPOLIS, IN46241            | <b> </b>   |                      |
|   | ST HEALTHCARE SUMMARY S (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | STREET 2<br>5225 W | W MORRIS ST  | r works on of the vill report of serious form existed for | (X5) COMPLETION DATE |
|   |  |   |                    | other placement; howeve resident once confronted actuality of leaving, refus | with the   |                      |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      |  | (X2) MULTIPLE CO | ONSTRUCTION   | (X3) DATE SURVEY  COMPLETED |  |
|--|----------------------|--|------------------|---|-----------------------------|--|
| ANDILAN  | or connection        | 15E667   | A. BUILDING      |   | 02/24/2011                  |  |
|  |                      |  | B. WING          | ADDRESS, CITY, STATE, ZIP CODE  |                             |  |
| NAME OF I  | PROVIDER OR SUPPLIER |  |                  | / MORRIS ST   |                             |  |
|  | ST HEALTHCARE        |  | INDIAN           | IAPOLIS, IN46241  |                             |  |
| (X4) ID  |                      | TATEMENT OF DEFICIENCIES                                 | ID               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE  | (X5)                        |  |
| PREFIX<br>TAG  |                      | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG    | CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)  | TE COMPLETION DATE          |  |
| TAG  | REGULATORY OR        | LSC IDENTIFYING INFORMATION)                             | TAG              | the alternate placement. Lynh is this resident's home and we hope to have the privelge to c for her for as long as she desi it to be. | urst<br>e<br>are            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15E667 |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING   |   | ONSTRUCTION         | (X3) DATE SURVEY  COMPLETED  02/24/2011   |   |                            |
|---|---|---|---|---------------------|---|---|----------------------------|
|   | PROVIDER OR SUPPLIER  | 1   | STREET ADDRESS, CITY, STATE, ZIP CODE  5225 W MORRIS ST INDIANAPOLIS, IN46241 |                     |   |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)  | TE  | (X5)<br>COMPLETION<br>DATE |
| F0431<br>SS=E   | interview, the face medications were on 10 of 19 vials basket kept in the the potential to a receiving insulin (Residents #7, #2 #9)  Findings included A undated policy Administrator on indicated "4. To insulin bottle with opening5. The opened insulin bottle with opening5. The opened insulin bottle date labeled of written on the bod dated and initialed An undated job of nurse, received fit 2/24/11 at 2:00 prindicated "Charpocumentation containers are significant of the portion of the polymer and polyme | d:  y titled "Insulin received from the 2/24/11 at 4:30 p.m., the nurse shall label the h a date and initials upon nurse shall dispose of ottles after 28 days from on the bottle (the date ttle when it is opened, and by the nurse)"  description for a staff from the Administrator on the and deemed current, | F04.  | 31                  | F04311) What actions will be accomplished for those reside found to have been affected by this deficient practice: Although residents were found to be affected by the listed medication to having 'open dates', the facility recognizes that pruden nursing practice mst be adhered to and that the potential for all residents to be affected by this deficiency must be avoided. The facility pharmacy performed an inspection, on 3/1/2011 and we return in two weeks to perform the same. Pharmacy will also utilize a monthly schedule of physically auditing the medical and treatment carts. All nursin staff (certified and licensed) which be in-serviced on the proper storage, opening containers a placing 'date of open' on the containers when opened. This in-service will be done by the facility and the pharmacy, on different dates and at different times, to ensure the message gets to the entire nursing staff. The nursing staff will be monitored weekly for three (3) months starting March 21st 2011 by the Director of Nursin (or her designee) to confirm the opened medication containers properly stored and labeled; be in the medication and treatmed carts and in the Medication Reproper. June 16th 2011 the monitoring schedule of the Director of Nursing (or her | ents y n no ons t ed s ne n iill n d g iat s are oth nt | 03/26/2011                 |

Facility ID:

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      | (X2) MULTIPLE CONSTRUCTION                               |             |             | (X3) DATE S<br>COMPL   |         |                    |
|--|----------------------|--|-------------|-------------|--|---------|--------------------|
| THIE TEXT  | or condition         | 15E667   | A. BUILDING |             |  | 02/24/2 |                    |
|  |                      |  | B. WING     | STREET A    | DDRESS, CITY, STATE, ZIP CODE  |         |                    |
| NAME OF F  | PROVIDER OR SUPPLIER |  |             |             | MORRIS ST  |         |                    |
|  | ST HEALTHCARE        |  |             |             | APOLIS, IN46241  |         |                    |
| (X4) ID  |                      | TATEMENT OF DEFICIENCIES                                 |             | ID          | PROVIDER'S PLAN OF CORRECTION  |         | (X5)               |
| PREFIX<br>TAG  | `                    | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |             | EFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) | E       | COMPLETION<br>DATE |
| IAG  |                      | al Nurse (LPN) #1, 19                                    | <u> </u>    | IAU         | designee) will be decreased to   | ,       | DATE               |
|  |                      | ` , ,  |             |             | bi-weekly for three (3) months   |         |                    |
|  | · •                  | nsulin were observed in a                                |             |             | and then go to a monthly basis   | s for   |                    |
|  |                      | ese vials, belonging to 8                                |             |             | the remainder of the year 2011   | · ·     |                    |
|  | · ·                  | t have the date opened                                   |             |             | How the facility will identify oth   |         |                    |
|  |                      | (Residents #7, #24, #35,                                 |             |             | residents having the potential be affected by the same deficient                       |         |                    |
|  | #14, #1, #10, #5     | and #9).   |             |             | practice and what corrective   | J. 11   |                    |
|  |                      |  |             |             | action will be taken:The facility  | ,       |                    |
|  | ~                    | iew with LPN #1 on                                       |             |             | pharmacy performed an  |         |                    |
|  | 2/24/11 at 12:45     | p.m. she indicated,                                      |             |             | inspection to include the  |         |                    |
|  | "We're always su     | pposed to label the vials                                |             |             | medication and treatment carts   | _       |                    |
|  | with open dates.'    | '  |             |             | and the Medication Room propon 3/1/2011 and will return in t                           |         |                    |
|  |                      |  |             |             | weeks from that date to perfor   | -       |                    |
|  | During an intervi    | iew with the   |             |             | the same. All insulin vials have   |         |                    |
|  | ~                    | 2/24/11 at 2:45 p.m.,                                    |             |             | been dated when opened or  |         |                    |
|  |                      | vials of insulin without                                 |             |             | replaced, at this time.Pharmac   | ;y      |                    |
|  |                      | ndicated "They know                                      |             |             | will also utilize a monthly schedule of physically auditing                            |         |                    |
|  | they're supposed     | •  |             |             | the medication and treatment   | '       |                    |
|  | everything they      | •  |             |             | carts and the Medication Roor  | n       |                    |
|  | everyuning mey (     | open.  |             |             | proper; to include, but not limit  | ed      |                    |
|  | 2.1.25(;)            |  |             |             | to, the insulin containers. All  |         |                    |
|  | 3.1-25(j)            |  |             |             | nursing staff ( certified and  |         |                    |
|  | 3.1-25(k)            |  |             |             | licensed) will be in-serviced or<br>the proper storage, opening                        | 1       |                    |
|  |                      |  |             |             | containers and placing 'date of  | F       |                    |
|  |                      |  |             |             | open' on the containers when   | ·       |                    |
|  |                      |  |             |             | opened.This in-service will be   |         |                    |
|  |                      |  |             |             | done by the facility and the   |         |                    |
|  |                      |  |             |             | pharmacy, on different dates a   |         |                    |
|  |                      |  |             |             | at different times, to ensure the message gets to the entire                           | t       |                    |
|  |                      |  |             |             | nursing staff. The nursing staff   | will    |                    |
|  |                      |  |             |             | be monitored weekly for three  |         |                    |
|  |                      |  |             |             | months starting March 21st   |         |                    |
|  |                      |  |             |             | 2011 by the Director of Nursing  |         |                    |
|  |                      |  |             |             | (or her designee) to confirm the   |         |                    |
|  |                      |  |             |             | all opened medication contains<br>are properly stored and labele                       |         |                    |
|  |                      |  |             |             | and property otoriou and labora  | ,       |                    |
|  |                      |  |             |             |  |         |                    |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                     |  | (X2) MULTIPLE CC | ONSTRUCTION   | (X3) DATE SURVEY  COMPLETED |
|---|---------------------|--|------------------|---|-----------------------------|
| 11112 12111                                   | or conduction       | 15E667   | A. BUILDING      |   | 02/24/2011                  |
|   |                     |  | B. WING          | ADDRESS, CITY, STATE, ZIP CODE  |                             |
| NAME OF P                                     | ROVIDER OR SUPPLIER |  |                  | / MORRIS ST   |                             |
| LYNHUR  | ST HEALTHCARE       |  |                  | IAPOLIS, IN46241  |                             |
| (X4) ID                                       |                     | TATEMENT OF DEFICIENCIES                                 | ID               | PROVIDER'S PLAN OF CORRECTION   | (X5)                        |
| PREFIX<br>TAG                                 |                     | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG    | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | COMPLETION DATE             |
| 1710  | REGOLATORI OR       | ESC ISENTIL TING IN ORWINION                             | ind              | both in the medication and  | DATE                        |
|   |                     |  |                  | treatment carts and in the  |                             |
|   |                     |  |                  | Medication Room proper.Jun  | e                           |
|   |                     |  |                  | 16th 2011 the monitoring schedule of the Director of                                  |                             |
|   |                     |  |                  | Nursing (or her designee) will  | be                          |
|   |                     |  |                  | decreased to bi-weekly for the  |                             |
|   |                     |  |                  | (3) months and then go to a   |                             |
|   |                     |  |                  | monthly basis for the remaind of the year 2011.3) What                                | er                          |
|   |                     |  |                  | systemic changes will be made   | de to                       |
|   |                     |  |                  | ensure the deficient practice   | does                        |
|   |                     |  |                  | not recur:Pharmacy will utiliz  | •                           |
|   |                     |  |                  | monthly schedule of physicall auditing the medication and                             | <b>у</b>                    |
|   |                     |  |                  | treatment carts and the   |                             |
|   |                     |  |                  | Medication Room proper; to  |                             |
|   |                     |  |                  | include, but not limited to, the  |                             |
|   |                     |  |                  | insulin containers. Pharmacy provide the Director of Nursin                           |                             |
|   |                     |  |                  | and the facility Administrator  | - 1                         |
|   |                     |  |                  | a full copy of their findings du  | ring                        |
|   |                     |  |                  | the audit. All nursing staff  |                             |
|   |                     |  |                  | (certified and licensed) will be in-serviced on the proper stor                       |                             |
|   |                     |  |                  | opening containers and placin   | •                           |
|   |                     |  |                  | 'date of open' on the containe  | rs                          |
|   |                     |  |                  | when opened. This in-service  | •                           |
|   |                     |  |                  | be done by the facility and the pharmacy, on different dates                          |                             |
|   |                     |  |                  | at different times, to ensure the   | •                           |
|   |                     |  |                  | message gets to the entire  |                             |
|   |                     |  |                  | nursing staff. The nursing staf   |                             |
|   |                     |  |                  | be monitored weekly for three months starting March 21st                              | ; (3)                       |
|   |                     |  |                  | 2011 by the Director of Nursir  | ng                          |
|   |                     |  |                  | (or her designee) to confirm t  | nat                         |
|   |                     |  |                  | all opened medication contain   | •                           |
|   |                     |  |                  | are properly stored and labele both in the medication and                             | ea;                         |
|   |                     |  |                  | treatment carts and in the  |                             |
|   |                     |  |                  |   |                             |
|   |                     |  |                  |   |                             |

| NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE  STREET ADDRESS, CITY, STATE, ZIT CODE 5225 W MORRIS ST INDIANAPOLIS, IN46241  INDIANAPOLIS, IN46241  REGULATORY OR LSC IDENTIFYING INFORMATION)  Medication Room proper. Non compliant employees will then be identified and counseled in writing, by the Director of Nursing, June 16th 2011 the monitoring schedule of the Director of Nursing (or designee) will be decreased to bi-weekly for three (3) months and then go to a monthly basis for the remainder of the year 2011. The facility will be scheduling a medication pass audit with the pharmacy and our Qualified Medication Aides, Each insulin vial medication rotationer will have colored dots placed on the tops of the containers; as a place indicating 'open dates' along with each vial being dated as when opened. This process will be audited starting March 21st 2011 by the same aforementioned parties 4/Responsibility for and monitoring for, the corrective actions for F0431-Pharmacy will utilize a monthly schedule of physically auditing the medication and treatment carts an anothal or physically auditing the medication and treatment carts an anothal schedule of physically auditing the medication and treatment carts and will being dated as when opened. This process will be audited starting March 21st 2011 by the same aforementioned parties 4/Responsibility for and monitoring for, the corrective actions for F0431-Pharmacy will utilize a monthly schedule of physically auditing the medication and treatment carts an anothal schedule of physically auditing the medication and treatment carts and the Medication Room proper; to include, but not limited to, the insulin containers. Pharmacy will provide the Director of Nursing and the facility Administrator with   | AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                     |                              | (X2) MULTIPLE CO       | ONSTRUCTION  | COMPLET   |      |  |  |
|---|---|---------------------|------------------------------|------------------------|--|---|------|--|--|
| NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG  Medication Room proper. Non compliant employees will then be identified and counseled in writing, by the Director of Nursing June 18th 2011 the monitoring schedule of the Director of Nursing (or designee) will be decreased to bi-weekly for three (3) months and then go to a monthly basis for the remainder of the year 2011. The facility will be scheduling a medication pass audit with the pharmacy and our Qualified Medication Aides. Each insulin vial medication container will have colored dots placed on the tops of the containers; as a place indicating 'open dates' along with each vial being dated as when opened. This process will be audited starting March 21st 2011 by the same aforementioned parties. 4)Responsibility for and monitoring for, the corrective actions for FO431:Pharmacy will utilize a monthly schedule of physically auditing the medication and treatment carts and the Medication Room proper; to include, but not limited to, the insulin containers. Pharmacy will provide the Director of Nursing and the facility Administrator with  |   |                     | 15E667                       | A. BUILDING<br>B. WING |  |   |      |  |  |
| LYNHURST HEALTHCARE  INDIANAPOLIS, IN46241  INA62241  INDIANAPOLIS, IN46241  INA62241   NAME OF P                                     | DOMED OF GUIDNING   |                              |                        | ADDRESS, CITY, STATE, ZIP CODE   |   |      |  |  |
| (X4) ID PRETIX (EACH DEFICIENCY MUST BE PERCEDED BY PULL. TAG (EACH DEFICIENCY ACTORS INCEDED TO THE APPROPRIATE CONS. PERCEDED TO THE APPROPRIATE (EACH DEFICIENCY DATE OF A PROPRE) (COMPLETO) DATE (EACH DEFICIENCY DATE OF A PROPRE) (EACH DATE OF A PROPRE OF A | NAME OF P                                     | ROVIDER OR SUPPLIER |                              |                        |  |   |      |  |  |
| PREFIX TAG REGULATORY OR I.S.C IDENTIFYING INFORMATION)  Medication Room proper. Non compilant employees will then be identified and counseled in writing, by the Director of Nursing, June 16th 2011 the monitoring schedule of the Director of Nursing (or designee) will be decreased to bi-weekly for three (3) months and then go to a monthly basis for the remainder of the year 2011. The facility will be scheduling all medication pass audit with the pharmacy and our Qualified Medication Aides. Each insulin vial medication container will have colored dots placed on the tops of the containers; as a place indicating open dates' along with each vial being dated as when opened. This process will be audited starting March 21st 2011 by the same aforementioned parties. 4)Responsibility for and monitoring for, the corrective actions for F0431:Pharmacy will utilize a monthly schedule of physically auditing the medication and treatment carts and the Medication Room proper; to include, but not limited to, the insulin containers. Pharmacy will provide the Director of Nursing and the facility Administrator with   | LYNHUR  | ST HEALTHCARE       |                              | INDIAN                 | NAPOLIS, IN46241   |   |      |  |  |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  Medication Room proper. Non compliant employees will then be identified and counseled in writing, by the Director of Nursing. June 16th 2011 the monitoring schedule of the Director of Nursing (or designee) will be decreased to bi-weekly for three (3) months and then got a monthly basis for the remainder of the year 2011. The facility will be scheduling a medication pass audit with the pharmacy and our Qualified Medication Aldes. Each insulin vial medication container will have colored dots placed on the tops of the containers; as a place indicating 'open dates' along with each vial being dated as when open. This process will be audited starting March 21st 2011 by the same aforementioned parties. 4)Responsibility for and monitoring for, the corrective actions for FC431:Pharmacy will utilize a monthly schedule of physically auditing the medication and treatment carts and the Medication Room proper; to include, but not limited to, the insulin containers. Pharmacy will provide the Director of Nursing and the facility Administrator with   |   |                     |                              | 1                      | PROVIDER'S PLAN OF CORRECTION  |   |      |  |  |
| Medication Room proper.Non compliant employees will then be identified and counseled in writing, by the Director of Nursing. June 16th 2011 the monitoring Schedule of the Director of Nursing June 16th 2011 the monitoring Schedule of the Director of Nursing (or designee) will be decreased to bi-weekly for three (3) months and then go to a monthly basis for the remainder of the year 2011. The facility will be scheduling a medication pass audit with the pharmacy and our Qualified Medication Aides. Each insulin vial medication container will have colored dots placed on the tops of the containers; as a place indicating 'open dates' along with each vial being dated as when opened. This process will be audited starting March 21st 2011 by the same aforementioned parties. 4)Responsibility for and monitoring for the corrective actions for F0431:Pharmacy will utilize a monthly schedule of physically auditing the medication and treatment carts and the Medication Room proper; to include, but not limited to, the insulin containers. Pharmacy will provide the Director of Nursing and the facility Administrator with   |   |                     |                              | 1                      | CROSS-REFERENCED TO THE APPROP   | RIATE   |      |  |  |
| a full copy of their findings during the audit. The Director of Nursing ( or her designee) will be responsible for monitoring the carts and the Medication Room, as per the set schedule above  | TAG   | REGULATORY OR       | LSC IDENTIFYING INFORMATION) | TAG                    | Medication Room proper. No compliant employees will the identified and counseled in writing, by the Director of Nursing. June 16th 2011 the monitoring schedule of the Director of Nursing (or designee) will be decreased bi-weekly for three (3) mont and then go to a monthly bathe remainder of the year 2011. The facility will be scheduling a medication paraudit with the pharmacy and Qualified Medication Aides. I insulin vial medication contawill have colored dots place the tops of the containers; a place indicating 'open dates along with each vial being das when opened. This procewill be audited starting Marce 21st 2011 by the same aforementioned parties. 4) Responsibility for a monitoring for, the corrective actions for F0431: Pharmacy utilize a monthly schedule ophysically auditing the mediand treatment carts and the Medication Room proper; to include, but not limited to, the insulin containers. Pharmacy and the facility Administrator a full copy of their findings of the audit. The Director of Nursand the facility Administrator a full copy of their findings of the audit. The Director of Nursand the Medication Room proper; to a full copy of their findings of the audit. The Director of Nursand the facility Administrator a full copy of their findings of the audit. The Director of Nursand the Medication Room propers and the M | en be  I to hs esis for ess dour each ess esh ess ess | DATE |  |  |

| AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15F667 |                      | A. BUILDING  | ONSTRUCTION   | COMPLETED  |                                   |            |
|--|----------------------|--|---------------|--|-----------------------------------|------------|
|  |                      | 15E667   | B. WING       |  | 02/24/2                           | U11        |
| NAME OF I  | PROVIDER OR SUPPLIER |  |               | ADDRESS, CITY, STATE, ZIP CODE   |                                   |            |
| LYNHUR   | ST HEALTHCARE        |  |               | / MORRIS ST<br>JAPOLIS, IN46241  |                                   |            |
| (X4) ID  |                      | TATEMENT OF DEFICIENCIES                                   | ID            | PROVIDER'S PLAN OF CORRECTION  |                                   | (X5)       |
| PREFIX<br>TAG  | *                    | CY MUST BE PERCEDED BY FULL  I SC IDENTIFYING INFORMATION) | PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)   | IATE                              | COMPLETION |
| TAG  | REGULATORY OR        | LSC IDENTIFYING INFORMATION)                               | TAG           | (#3)Non compliant employee then be identified and couns in writing, by the Director of Nursing.Any reoccurrences to be followed by placing those employees found responsible the corrective counseling pro | es will<br>eled<br>vill<br>e into | DATE       |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15E667 |                      | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |        |        | (X3) DATE S<br>COMPL<br><b>02/24/2</b>                               | ETED    |            |
|---|----------------------|---|--------|--------|--|---------|------------|
|   |                      | 132007                                  | B. WIN |        |  | 02/24/2 | 011        |
|   | PROVIDER OR SUPPLIER |   |        | 5225 W | ADDRESS, CITY, STATE, ZIP CODE  / MORRIS ST                          |         |            |
| LYNHUR  | ST HEALTHCARE        |   |        | INDIAN | IAPOLIS, IN46241   |         |            |
| (X4) ID   | SUMMARY S            | TATEMENT OF DEFICIENCIES                |        | ID     | PROVIDER'S PLAN OF CORRECTION  |         | (X5)       |
| PREFIX  | `                    | CY MUST BE PERCEDED BY FULL             |        | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E       | COMPLETION |
| TAG   | REGULATORY OR        | LSC IDENTIFYING INFORMATION)            | ļ      | TAG    | DEFICIENCY)  |         | DATE       |
| F0460   | Based on observa     | ations, the facility failed             | F04    | 60     | F04601) All residents have the                                       | ;       | 03/26/2011 |
| SS=E  | to ensure all priv   | acy curtains functioned                 |        |        | potential to be affected by this deficient practice: Although no     |         |            |
|   | properly affecting   | g 10 out of 36 residents                |        |        | residents were found to be   |         |            |
|   | who reside in the    | facility. The lack of                   |        |        | affected by the small openings                                       | in      |            |
|   | proper functioning   | ng privacy curtains                     |        |        | their privacy curtains, the facili                                   |         |            |
|   |                      | s who reside in rooms 1,                |        |        | recognizes that prudent dignity                                      | /       |            |
|   | 3, 5, and 6.         | ,                                       |        |        | and privacy practices must be  | :-1     |            |
|   | 2,2,000              |   |        |        | adhered to and that the potent for all residents to be affected      |         |            |
|   | Findings include     | d·                                      |        |        | this deficiency must be  | Бу      |            |
|   | 1 manigs merade      | u.                                      |        |        | avoided.Privacy curtain audit h                                      | nas     |            |
|   | During the 2/24/     | 11 10:00 a m                            |        |        | been completed as of this date                                       |         |            |
|   | During the 2/24/     |   |        |        | 3/15/2011).An evaluation of ea                                       | ich     |            |
|   |                      | ur, the privacy curtains                |        |        | resident's room and of all   |         |            |
|   |                      | oth bed spaces would not                |        |        | common areas has been  |         |            |
|   | _                    | exposed area of at least                |        |        | completed.Rooms 1, 3,5 and 6: The privacy curtain tracks a           | re      |            |
|   | 2 feet. There are    | 2 residents who reside in               |        |        | currently being adjusted by the                                      |         |            |
|   | room 1.              |   |        |        | Maintenance Director. 2) How   |         |            |
|   |                      |   |        |        | facility will ID other resident                                      |         |            |
|   | The privacy curta    | ain for room 3 bed space                |        |        | having the potential to be affect                                    | cted    |            |
|   | 2 would not pull     | shut with an exposed                    |        |        | by the same deficient practice and what corrective action will       | ho      |            |
|   | area of at least 2   | feet. There are 2                       |        |        | taken:The Maintenance Direct   |         |            |
|   | residents who res    | side in room 3.                         |        |        | will make his inspection round                                       |         |            |
|   |                      |   |        |        | each resident room and all   |         |            |
|   | In room 5 hed sr     | pace 1 had no privacy                   |        |        | common areas, on a weekly  |         |            |
|   | _                    | 5, bed space 2, the                     |        |        | basis for the next three (3)   |         |            |
|   |                      | -                                       |        |        | months with a written report gi                                      |         |            |
|   |                      | yould not pull shut, with               |        |        | to the Director of Nursing and Administrator. After three (3)        | uie     |            |
|   | -                    | of at least 2 feet. There               |        |        | months, the inspection rounds  | will    |            |
|   | are 2 residents w.   | ho reside in room 5.                    |        |        | decrease to bi-weekly for two  |         |            |
|   |                      | _                                       |        |        | months; with a written report  |         |            |
|   | •                    | vacy curtains would not                 |        |        | given to the Director of Nursing                                     | •       |            |
|   |                      | exposed area from 10                    |        |        | and the Administrator. After the                                     |         |            |
|   | inches to 2 feet.    | There are 4 residents                   |        |        | latter two (2) month period the inspection rounds will decreas       |         |            |
|   | who reside in roo    | om 6.                                   |        |        | a monthly basis, with written  |         |            |
|   |                      |   |        |        | reports given to the Director of                                     | :       |            |
|   |                      |   |        |        |  |         |            |

Facility ID:

| AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |   | li i   | COMPLETED   |                      |  |
|--|--|---|---|--|---|----------------------|--|
|  |  | 15E667  | B. WING 02/24/2011  |  |   |                      |  |
|  | PROVIDER OR SUPPLIER                       |   | STREET ADDRESS, CITY, STATE, ZIP CODE  5225 W MORRIS ST INDIANAPOLIS, IN46241 |  |   |                      |  |
|  | ST HEALTHCARE  SUMMARY S'  (EACH DEFICIENT | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | 5225 W  | W MORRIS ST  | ator. te' pection (or her hese s, ttor of nds will form. 3) e facility he de esident s on ce pection ort given and the ( 3) unds will two (2) ort ursing er the d the rease to en or of ator. te' pection | (X5) COMPLETION DATE |  |
|  |  |   |   | designee) will also make to monthly inspection rounds accompanied by the Direct Nursing.All inspection rounds accompanied by the Direct Nursing. | hese<br>s,<br>etor of   |                      |  |

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667                          | A (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                            |  | (X3) DATE SURVEY COMPLETED 02/24/2011   |  |  |
|--------------------------|------------------------------------|---|---|--|---|--|--|
|                          | ROVIDER OR SUPPLIER                |   | STREET ADDRESS, CITY, STATE, ZIP CODE  5225 W MORRIS ST INDIANAPOLIS, IN46241 |  |   |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | 5.112   |  |  |
|                          |                                    |   |   | be documented in written form Responsibility for and monitor for, the corrective actions for F0253:The Maintenance Direct will be responsible to docume all inspection rounds, to include all resident furniture and lighting, in writting and forward these to the Director of Nursimand the Administrator of the facility. The Maintenance Direct will make his inspection round each resident room and all common areas, on a weekly basis for the next three (3) months with a written report gothe Director of Nursing and Administrator. After three (3) months, the inspection rounds decrease to bi-weekly for two months; with a written report given to the Director of Nursing and the Administrator. After the latter two (2) month period the inspection rounds will decrease a monthly basis, with written reports given to the Director of Nursing and the Administrator. There will be 'No Stop Date' placed on the monthly inspection rounds, accompanied by the Director of Nursing. All inspection rounds be documented in written form | ctor nt de d g ctor ls in  iven the s will (2) g e e f or f or dion her e of will |  |  |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CONSTRUCTION   |         | (X3) DATE SURVEY |   |               |            |
|--|----------------------|------------------------------|---------|------------------|---|---------------|------------|
| AND PLAN   | OF CORRECTION        | IDENTIFICATION NUMBER:       | A. BUIL | DING             |   | COMPLETED     |            |
|  |                      | 15E667                       | B. WING |                  |   | 02/24/2011    |            |
|  |                      | <u> </u>                     |         |                  | ADDRESS, CITY, STATE, ZIP CODE  |               |            |
| NAME OF F  | PROVIDER OR SUPPLIER | L.                           |         |                  | MORRIS ST   |               |            |
|  | ST HEALTHCARE        |                              |         | INDIAN           | IAPOLIS, IN46241  |               |            |
| (X4) ID  |                      | TATEMENT OF DEFICIENCIES     |         | ID               | PROVIDER'S PLAN OF CORRECTION   |               | (X5)       |
| PREFIX   | · ·                  | CY MUST BE PERCEDED BY FULL  |         | PREFIX           | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | ΤE            | COMPLETION |
| TAG  |                      | LSC IDENTIFYING INFORMATION) | +       | TAG              | DEFICIENCY)   |               | DATE       |
| F0463  |                      | ation and interview, the     | F040    | 63               | F04631) What actions will be  | 1-            | 03/26/2011 |
| SS=D   | facility failed to   | ensure that all call lights  |         |                  | accomplished for those reside found to have been affected by          |               |            |
|  | were working. T      | The non functioning call     |         |                  | this dificient practice:As attested                                   |               |            |
|  | light affected the   | resident who resides in      |         |                  | in the ISDH survey report 201   |               |            |
|  | room 15 bed spa      |                              |         |                  | this nonfunctioning call light, o                                     |               |            |
|  | 1                    | call light affected 1 out of |         |                  | identified, was attended to   |               |            |
|  |                      | reside in the facility.      |         |                  | immediately and in working  |               |            |
|  | Jo residents who     | reside in the facility.      |         |                  | condition prior to the exit of ou                                     |               |            |
|  |                      |                              |         |                  | surveyors that day.Call lights a                                      |               |            |
|  | Findings include     | d:                           |         |                  | checked on a weekly basis for function and more so on a dail          |               |            |
|  |                      |                              |         |                  | basis by the nursing staff who  |               |            |
|  | During the 2/24/     |                              |         |                  | performing direct patient care.                                       | aic           |            |
|  | environmental to     | our, the call light in room  |         |                  | (Although, the nursing checks   | are           |            |
|  | 15-2 would not to    | urn the light or bell alarm  |         |                  | not in written form, unless a lig                                     |               |            |
|  | on.                  |                              |         |                  | is discovered to be malfunction                                       | ning          |            |
|  |                      |                              |         |                  | and then it is written into the                                       |               |            |
|  | During an intervi    | iew on 2/24/2011 at          |         |                  | maintenance log book; for the   |               |            |
|  | _                    | the maintenance man, he      |         |                  | Maintenance Directors daily   |               |            |
|  |                      | e call bell in room 15 bed   |         |                  | review.)2) How the facility will identify other residents having      |               |            |
|  |                      |                              |         |                  | potential to be affected by the                                       | 110           |            |
|  | 2 was working no     | ow.                          |         |                  | same deficient practice and wl  | nat           |            |
|  |                      |                              |         |                  | corrective action will be taken:                                      |               |            |
|  | 3.1-19(u)(1)         |                              |         |                  | resident have the potential to t                                      |               |            |
|  |                      |                              |         |                  | affected by this deficiency.Cal                                       |               |            |
|  |                      |                              |         |                  | lights are checked on a weekly  |               |            |
|  |                      |                              |         |                  | basis for function and more so  |               |            |
|  |                      |                              |         |                  | a daily basis by the nursing sta<br>who are performing direct pation  |               |            |
|  |                      |                              |         |                  | care.(Although, the nursing   | CIIL          |            |
|  |                      |                              |         |                  | checks are not in written form,                                       |               |            |
|  |                      |                              |         |                  | unless a light is dicovered to b                                      |               |            |
|  |                      |                              |         |                  | malfunctioning and then it is   |               |            |
|  |                      |                              |         |                  | written into the maintenance lo                                       | og            |            |
|  |                      |                              |         |                  | book; for the Maintenance   |               |            |
|  |                      |                              |         |                  | Directors daily review.)The   |               |            |
|  |                      |                              |         |                  | Administrator and the Maintenance Director made                       |               |            |
|  |                      |                              |         |                  | inspection/environmental roun   | <sub>ds</sub> |            |
|  |                      |                              |         |                  |   |               |            |
|  |                      |                              | 1       |                  |   |               |            |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15E667 |                 | A. BUILDING   |                     | COMPLETED 02/24/2011   |  |
|---|-----------------|---|---------------------|--|--|
|   |                 | 102001  | B. WING             | ADDRESS CITY STATE ZIR CODE  | 02/27/2011   |
| NAME OF PROVIDER OR SUPPLIER                          |                 |   |                     | ADDRESS, CITY, STATE, ZIP CODE  / MORRIS ST  |  |
| LYNHUR  | ST HEALTHCARE   |   |                     | IAPOLIS, IN46241   |  |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES<br>CY MUST BE PERCEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | (X5) COMPLETION DATE   |
|   |                 |   |                     | of the resident rooms and common areas on 2/28/2011. Maintenance Director will make his inspection rounds in each resident room and all common areas, on a weekly basis for the next three (3) months with a written report given to the Director of Nursing and the Administrat After three (3) months, the inspection rounds will decrease bi-weekly for two (2) months; a written report given to the Director of Nursing and the Administrator. To begin March 21st, 2011. These rounds will include call light systems. After latter two (2) month period the inspection rounds will decrease a monthly basis, with written reports given to the Director of Nursing, the Administrator and the Housekeeping Supervisor. There will be 'No Date' placed on the monthly inspection rounds. The Administrator (or her designed will also make these monthly inspection rounds, accompaning by the Director of Nursing. All inspection rounds will be documented in written form. 3) The systemic changes the fact has made, to prevent reoccurrence of this tag: The Administrator and the Maintenance Director made inspection/environmental rour of the resident rooms and common areas on 2/28/2011. Maintenance Director will make maintenance Director will make the precious and common areas on 2/28/2011. | The ke  In the ector tor.  Se to with  If the ector tor.  Stop  St |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15E667 |   | A. BUILDING  | COMPLETED 02/24/2011   |  |  |  |
|---|---|--|--|--|--|--|
|   | 135007  | B. WING  | 02/24/2011   |  |  |  |
| NAME OF PROVIDER OR SUPPLIE   |   | STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN46241   |  |  |  |  |
| PREFIX (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PERCEDED BY FULL<br>R LSC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP TAG DEFICIENCY)   | ULD BE COMPLETION PROPRIATE DATE   |  |  |  |
|   |   | his inspection rounds in resident room and all co areas, on a weekly basis next three (3) months wi written report given to the of Nursing and the Admi After three (3) months, inspection rounds will de bi-weekly for two (2) mo a written report given to Director of Nursing and Administrator. These rou include call light systems latter two (2) month perinspection rounds will de a monthly basis, with wr reports given to the Dire Nursing, the Administrate the Housekeeping Supervisor. There will be Date' placed on the morn inspection rounds. The Administrator (or her dewill also make these moninspection rounds, according to the Director of Nursing inspection/environmenta will be documented in whorm.4) Responsibility formonitoring for, the correlations for F0463Call light checked on a weekly band function and more so on basis by the nursing state performing direct patient (Although, the nursing contin written form, unless is discovered to be malfit and then it is written into maintenance log book; for Maintenance Directors of Maintenanc | immon is for the ith a ie Director inistrator. ithe ecrease to inths; with ithe ithe inds will is.After the od the ecrease to itten ctor of or and ie 'No Stop ithly signee) inthly mpanied ig.All ial rounds ritten or and ctive ihts are sis for ia daily iff who are it care. hecks are is a light unctioning of the or the |  |  |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15E667 |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  | (X3) DATE SURVEY COMPLETED 02/24/2011 |   |    |  |
|---|--|---|--|---------------------------------------|---|----|--|
| NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE   |  |   | B. WING 02/24/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  5225 W MORRIS ST  INDIANAPOLIS, IN46241 |                                       |   |    |  |
|   | ST HEALTHCARE  SUMMARY S  (EACH DEFICIENCE |   | STREET . 5225 W  | V MORRIS ST                           | (X5) COMPLETIC DATE  rector cally iting ental | ON |  |
|   |  |   |  |                                       |   |    |  |

| STATEMENT OF DEFICIENCIES    |   | X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE CONSTRUCTION |        | (X3) DATE SURVEY   |                       |                    |
|------------------------------|---|------------------------------|----------------------------|--------|--|-----------------------|--------------------|
| AND PLAN OF CORRECTION       |   | IDENTIFICATION NUMBER:       | A DUH DING                 |        | COMPLETED  |                       |                    |
|                              |   | 15E667                       | A. BUILDING B. WING        |        |  | 02/24/2011            |                    |
|                              |   |                              |                            |        | ADDRESS, CITY, STATE, ZIP CODE   |                       |                    |
| NAME OF PROVIDER OR SUPPLIER |   |                              |                            |        | MORRIS ST  |                       |                    |
| LYNHURST HEALTHCARE          |   |                              |                            | 1      | APOLIS, IN46241  |                       |                    |
|                              |   |                              |                            |        | Al OLIO, 114-02-1  |                       |                    |
| (X4) ID                      |   | TATEMENT OF DEFICIENCIES     | ID                         |        | PROVIDER'S PLAN OF CORRECTION  |                       | (X5)<br>COMPLETION |
| PREFIX                       |   | CY MUST BE PERCEDED BY FULL  |                            | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) | ED TO THE APPROPRIATE |                    |
| TAG                          |   | LSC IDENTIFYING INFORMATION) |                            | TAG    |  |                       | DATE               |
| F0469                        |   | ation, record review and     | F04                        | 69     | F04691) What actions will be accomplished for those reside                             | nte                   | 03/26/2011         |
| SS=F                         | interview, the fac  | cility failed to ensure they |                            |        | found to have been affected by   |                       |                    |
|                              | maintained an ef  | fective pest control         |                            |        | the deficient practice: All  | y                     |                    |
|                              | program so the fa   | acility was free of flying   |                            |        | residents have the potential to  | be                    |                    |
|                              | insects. This had   | the potential to affect 36   |                            |        | affected by this   |                       |                    |
|                              |   | ts residing in the facility  |                            |        | deficeincy.However, under fur  |                       |                    |
|                              | who ate in the di   |                              |                            |        | review, no resident was affected   | ed                    |                    |
|                              | who are in the ar   | ming room.                   |                            |        | negatively in this particular  | -4 - d                |                    |
|                              | Eindings in aluda   | <b>4.</b>                    |                            |        | instance. The facility is contract with ORKIN pest control. This                       | ciea                  |                    |
|                              | Findings include  | a.                           |                            |        | provider performed services of   | n                     |                    |
|                              |   |                              |                            |        | 1/26/11 and 2/23/11 in our   |                       |                    |
|                              | An undated facility policy, received from   |                              |                            |        | kitchen/dietary areas.The facil  | ity                   |                    |
|                              | the Administrator on 2/24/11 at 3:30 p.m.   |                              |                            |        | has replaced a non-working   |                       |                    |
|                              | and deemed current, titled "Pest Control"   |                              |                            |        | electric bug control device.The  |                       |                    |
|                              | indicated "[name of facility] will strive to  |                              |                            |        | facility has also ordered anoth  |                       |                    |
|                              | maintain a pest free environment for the health and comfort of all our residents and our staff" |                              |                            |        | device that is battery powered<br>and fully contained and safe to                      |                       |                    |
|                              |   |                              |                            |        | located in the kitchen area.Dra  |                       |                    |
|                              |   |                              |                            |        | inside the kitchen have also be  |                       |                    |
|                              | our surre   |                              |                            |        | cleaned . 2) How the facility w  |                       |                    |
|                              | The following of  | oservations were made:       |                            |        | identify other residents having  | the                   |                    |
|                              | The following of  | oservations were made.       |                            |        | potential to be affected by the  |                       |                    |
|                              |   |                              |                            |        | same deficient practice and wl   |                       |                    |
|                              |   | a.m.: 3 small black bugs     |                            |        | corrective action will be taken:   |                       |                    |
|                              |   | inside the kitchen near      |                            |        | residents have the potential to<br>affected by this deficeincy.In                      | De                    |                    |
|                              | the entry door.   |                              |                            |        | addition to the corrective actio   | ns                    |                    |
| 2/21/11 at 10:45             |   | a.m.: approximately 8        |                            |        | as listed in number (1);Orkin h  |                       |                    |
|                              | small black bugs  | were seen flying near a      |                            |        | provided instructions regarding  |                       |                    |
|                              | trash can placed over a drain in the  |                              |                            |        | having a continuous air flow o   |                       |                    |
|                              | •   | oor exiting into the dining  |                            |        | the drain located under the dis  |                       |                    |
|                              | room.   |                              |                            |        | machine. The trash cans in the   | e                     |                    |
|                              | 2/22/11 at 9:30 a.m.: approximately 4 small black bugs were seen flying near the                |                              |                            |        | kitchen will be cleansed thouroughly, daily, inside and                                |                       |                    |
|                              |   |                              |                            |        | out, after each meal service ha  | as I                  |                    |
|                              |   |                              |                            |        | been completed.Grouted   |                       |                    |
|                              | same trash can.   |                              |                            |        | areas around the drains,   |                       |                    |
|                              |   | a.m.: 1 small black bug      |                            |        | dishwasher and sink, are being   | g                     |                    |
|                              | was seen flying a   | at the entrance to Room 3.   |                            |        | regrouted to provide a tighter   |                       |                    |
|                              |   |                              |                            |        |  |                       |                    |

Facility ID:

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION      |        |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|---------------------------------|--------|--|-------------------------------|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E667 |  | A. BUILDING  |                                 |        |  |                               |  |
| 15E007   |  |  | B. WING 02/24/2011              |        |  | 02/24/2011                    |  |
| NAME OF PROVIDER OR SUPPLIER                         |  |  |                                 | 1      | ADDRESS, CITY, STATE, ZIP CODE   |                               |  |
| LVALUEDOT LICAL THOADE                               |  |  |                                 |        | / MORRIS ST  |                               |  |
|  | ST HEALTHCARE  |  |                                 | INDIAN | IAPOLIS, IN46241   |                               |  |
| (X4) ID  |  | TATEMENT OF DEFICIENCIES                             |                                 | ID     | PROVIDER'S PLAN OF CORRECTION  |                               |  |
| PREFIX   |  | CY MUST BE PERCEDED BY FULL                          |                                 | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) |                               |  |
| TAG  | REGULATORY OR  | LSC IDENTIFYING INFORMATION)                         | +                               | TAG    | seal.The floor drains have bee   | DATE                          |  |
|  | 2/24/11 at 3:40 p  | .m.: 1 small black bug                               |                                 |        | placed on a cleaning schedule  |                               |  |
|  | was seen flying i  | _  | that will occur nightly for the |        |  |                               |  |
|  |  |  |                                 |        | remainder of 2011.3) The systemic changes the facility h                               | 128                           |  |
|  | During a groun ii  | nterview on 2/22/11 at                               |                                 |        | made, to prevent reoccurrence  |                               |  |
|  | 11:00 a.m., all re   |  |                                 |        | this tag: The facility is contract   |                               |  |
|  | · ·  | 1, #20, #29, #7, #14, and                            |                                 |        | with ORKIN pest control. This  |                               |  |
|  | `  | ere were "gnats" in the                              |                                 |        | provider performed services of 1/26/11 and 2/23/11 in our                              | n                             |  |
|  | · ·  | ere were ghats in the                                |                                 |        | kitchen/dietary areas. This  |                               |  |
|  | dining room.   |  |                                 |        | contractor has been informed   | that                          |  |
|  | During an interview with Resident #9 on 2/24/11 at 2:30 p.m., she indicated there were "gnats everywhere in the dining room."  During an interview with the Maintenance  |  |                                 |        | more measures are required to  |                               |  |
|  |  |  |                                 |        | prevent "gnats" and they are in  |                               |  |
|  |  |  |                                 |        | agreement and will perform the   |                               |  |
|  |  |  |                                 |        | work that is required. The facili has replaced a non-working                           | ty                            |  |
|  |  |  |                                 |        | electric bug control device that   | is                            |  |
|  |  |  |                                 |        | located in a far corner of the   |                               |  |
|  |  |  |                                 |        | dining area. The facility has als  | 0                             |  |
|  |  | /11 at 1:30 p.m., he                                 |                                 |        | ordered another device that is   |                               |  |
|  | indicated "The pe  | est control people spray                             |                                 |        | battery powered and fully contained and safe to be locat                               |                               |  |
|  | the drain in the kitchen and that seems to   |  |                                 |        | in the kitchen area.Drains insid   |                               |  |
|  | help."   |  |                                 |        | the kitchen have also been   |                               |  |
|  |  |  |                                 |        | cleaned . Orkin has provided   |                               |  |
|  | During an intervi  | iew with the   |                                 |        | instructions regarding having a  |                               |  |
|  | Administrator on   | 2/24/11 at 11:30 am she                              |                                 |        | continuous air flow over the dr located under the dish machin                          |                               |  |
|  | indicated "I've talked to the pest control company and asked them to do something."  A review of the last receipt from a local pest control company, dated 2/22/11, did not indicate that the company treated the building or rooms for gnats. |  |                                 |        | The trash cans in the kitchen  |                               |  |
|  |  |  |                                 |        | be cleansed thouroughly, daily   |                               |  |
|  |  |  |                                 |        | inside and out, after each mea   | ı                             |  |
|  |  |  |                                 |        | service has been   | _                             |  |
|  |  |  |                                 |        | completed.Grouted areas arou   | ina                           |  |
|  |  |  |                                 |        | the drains, dishwasher and sink, are being regrouted to                                |                               |  |
|  |  |  |                                 |        | provide a tighter seal. The floor  | .                             |  |
|  |  |  |                                 |        | drains have been placed on a   |                               |  |
|  |  |  |                                 |        | cleaning schedule that will occ  | ur                            |  |
|  | 3 1_10(f)(2)   |  |                                 |        | nightly for the remainder of 2011. The areas around the                                |                               |  |
|  | 3.1-19(f)(3)   |  |                                 |        | 2011.THE areas around the  |                               |  |
|  |  |  |                                 |        |  |                               |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15E667 |                | (X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING   |   | (X3) DATE SURVEY COMPLETED 02/24/2011   |   |  |  |
|---|----------------|---|---|---|---|--|--|
| NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE   |                |   | STREET ADDRESS, CITY, STATE, ZIP CODE  5225 W MORRIS ST INDIANAPOLIS, IN46241 |   |   |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES<br>CY MUST BE PERCEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  |   |  |  |
|   |                |   |   | machines will be kept clean and dry on a meal to meal basis to ensure that moisture does not attract these insects. The facili will also continue with all othe measures that are in use to prevent reoccurrence. 4) Responsibility for and monitor for, the corrective actions for F0469: The Maintenance Direct will assume responsibility to compare drains nightly. Along with regrouting areas around the drains in the kitchen. He will all be responsible for the cleaning the trash cans daily, inside an out, after each meal service hearn completed. The Maintenance Director will also maintain checking insect continuity, to ensure workin order his scheduled rounds of the interior of the building. (see F253) The Dietary Supervisor be accountable for ensuring areas around the machines at kept clean and dry. | ty r ing ctor lean so g of d as rol iis r, on |  |  |